CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	JG	00	COMPL	ETED
		155089		B. WING		06/04/2013	
e e e				TREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	· ·	10	023 N	20TH ST		
HERITA	GE HOUSE OF NE	W CASTLE	N	IEW CA	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	II	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E (	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	Tz	AG	DEFICIENCY)		DATE
F000000							
	This visit was f	for the Recertification	F00000	00	F0000Preparation and/or		
		nsure Survey. This visit	10000		execution of This Plan of		
	included the In	<u>-</u>			Correction in generalor any		
	Compliant IN0	•			corrective action set forth here	in,	
	Compliant into	0127901.			in particular, does not		
	Complaint INO	0107001			constitutean admission or	of	
	Complaint INO				agreement by Heritage House New Castle of the facts allege		
	Substantiated.				the conclusions set forth in the		
		ted the allegation is			statement of deficiencies.The		
	cited at F-166.				Plan of Correction and specific	2	
					corrective actions are prepare		
	1	May 28, 29, 30, 31,			and/or executedsolely becaus		
	June 3, & 4, 20	013			provisions of federal and/or stallaws. Heritage House desires		
					Plan of Correction to be	แแร	
	Facility numbe	r: 000035			considered the facility's Allega	ition	
	Provider numb	er: 155089			of Compliance. Compliance is		
	AIM number:	100266250			effective July 4, 2013 .This		
					building respectfully requests		
	Survey team:				consideration for paper		
	Angel Tomlins	on RN TC			compliance from the Plan of Correction.		
	Sharon Lasher				Correction.		
	Barbara Gray						
	Leslie Parrett F						
	Lesile i airetti	XIV					
	Census bed ty	pe:					
	SNF/NF: 53	r					
	Total: 53						
	10141. 00						
	Census payor	type:					
	Medicare: 5						
	Medicaid: 39						
	Other: 9						
	Total: 53						
	1		1				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TITLE

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155089	(X2) MULTIPLE CO  A. BUILDING  B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/04/2013
NAME OF F	PROVIDER OR SUPPLIE	₹		ADDRESS, CITY, STATE, ZIP CODE  20TH ST	
HERITAC	GE HOUSE OF NE	W CASTLE	NEW C	ASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		cies also reflect state n accordance with 410			
	Quality review Williams, RN	6/13/13 by Suzanne			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VCG611

Facility ID: 000035

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155089	B. WING			06/04/	
			D. 17111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				20TH ST		
HERITAG	E HOUSE OF NEV	V CASTLE			ASTLE, IN 47362		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F000166	483.10(f)(2)						
SS=D		IPT EFFORTS TO					
	RESOLVE GRIEV						
		e right to prompt efforts by lve grievances the resident					
		ng those with respect to					
	the behavior of ot						
		rvation, interview and	F00	0166	Heritage House will continue to	n	07/04/2013
		the facility failed to	100	0100	ensure all residents have the r		0770172013
	resolve grievan				to prompt efforts by the facility	•	
	•				resolve grievances the resider		
		are not being done			may have, including those with		
	•	resident reviewed for			respect to the behavior of othe	er	
		ly living, cleanliness			residents.1 A grievance	<b>.</b> .	
		of 1 resident who met			(complaint/ concern) form will filled out for resident D's family		
	the criteria for a	activities of daily living,			and handled appropriately.	′	
	cleanliness and	d grooming (Resident			Attachment #3. Resident D's		
	#D)				family member alleged		
					grievances regarding		
	Finding include	:			incontinence care would have		
	•				been promptly investigated		
	Interview with F	Resident #D's family			and resolved if found to be factual. The family member of		
		28-13 at 10:01 a.m.			Resident D has filled out two		
		isited Resident #D			previous resident		
		ily basis and all			concern/complaint forms in the	;	
		of the day and night.			past and these grievances we		
		•			handled to her satisfaction. Sh	е	
	The family mer				was informed at admission how		
	Resident #D di				to file a grievance. Attachment	: #4	
		toileting needs. The			A,B,C,D2. Any resident with a grievance has the potential to	he	
	•	indicated Resident #D			affected. Complaint/concern	DC .	
		with urine and soiled			forms will be placed at each		
	with bowel mov	ement frequently. The			nurses station.3. All staff will b	е	
	family member	indicated she felt			inserviced July 1, 2013 re:		
	there were not	enough staff working			complaints/concerns and how		
	at the facility, a	-			these are to be handled. 4. So	cial	
	•	on night shift there			Services will monitor all	2	
		sident #D would be			complaint/concerns weekly for months and monthly for 3	3	
			l				l

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Event ID: VCG611

Facility ID: 000035

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED	
		155089	B. WIN			06/04/2013	
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	S. C.			20TH ST		
HERITAC	GE HOUSE OF NEV	V CASTLE			ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	incontinent and	the family member			months. Social Services will		
	would not be a	ble to find any staff			randomly question 3 residents	or	
	available to cha	ange the resident . The			their family/responsible party weekly for 3 months and 6		
	family member	indicated the resident			residents or their		
	was found to h	ave urine soaked			family/responsible party month	nly	
	clothes and bo	wel movement all the			for 3 months. Results will be		
	way up her bad				reported to the QA committee	for	
		nily member indicated			review/recommendations.		
		as unable to clean			Attachment #5.IDR:Resident # daughter did not file a grievand		
		family member			with anyone at the facility. See		
		nad timed how long it			attachments.		
		istance and it had been					
		es. The family member					
	· •	nad talked with the					
		rsing (DON) about					
		s and nothing ever gets					
	resolved. The f						
		ng had changed since					
	· ·	ed her concerns to the					
		ily member indicated					
		with the DON about					
		s within the past two					
		mily member indicated					
	1	urine odor almost					
	1 .	n she visits. The family					
		ted the facility had					
		fill out a grievance					
		ly member indicated a					
		en she would come to					
	visit, Resident	#D would be sitting in					
	the dining roon	n wet with urine and					
	she wondered	how long had Resident					
	#D had been s	itting in the dining room					
ı	wet. During the	interview there was a					
	strong urine oc	lor observed outside					

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Event ID: VCG611

Facility ID: 000035

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	OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:  155089	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SUR COMPLETE 06/04/201	ED
	PROVIDER OR SUPPLIER  GE HOUSE OF NEW CASTLE	1023 N	ADDRESS, CITY, STATE, ZIP CODE 20TH ST ASTLE, IN 47362		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE CO	(X5) OMPLETION DATE
	Resident #D's bedroom.  Review of the record of Resident #D on 5-31-13 at 2:03 p.m. indicated the resident's diagnoses included, but were not limited to, hypothyroidism, Alzheimer's dementia, depression, urinary incontinence, insomnia, diarrhea and leg pain.  The Minimum Data Set (MDS) assessment for Resident #D dated 4-25-13 indicated the following: the resident's BIMS score (Brief Interview for Mental Status) was 3- severe impairment, the resident required extensive assistance of one person for toileting needs, was frequently incontinent of urine and always incontinent of her bowel.  Interview with the Social Service Director S.S.D. on 5-30-13 at 10:35 a.m. indicated the facility had not received any grievances on incontinent care not being done timely or lack of staffing. The S.S.D. indicated if a resident or a family member had complained about these issues a grievance form would have been filled out.  During interview with the DON on 6-3-13 at 10:57 a.m. regarding if a grievance form had been completed				

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	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  OF CORRECTION (IDENTIFICATION NUMBER:  155089	(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/04/2013
	PROVIDER OR SUPPLIER  GE HOUSE OF NEW CASTLE	1023 N	ADDRESS, CITY, STATE, ZIP CODE 20TH ST ASTLE, IN 47362	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE COMPLETION
	for Resident #D's family member's concerns about the resident being found wet with urine and soiled with bowel movement and the facility not having enough staff to give assistance with the resident's toileting needs, the DON indicated she did not fill out a grievance form. The DON indicated the S.S.D. was the one who filled out the grievance forms. The DON indicated Resident #D's family had reported these concerns to her but she felt like it was just a conversation and so she did not need to fill out a grievance. The DON indicated she went over the number of staff the facility had on each shift with Resident #D's family member and the family member appeared to be satisfied with this.  Review of the "resident/family concerns or complaints" policy provided by the S.S.D. on 5-31-13 at 8:55 a.m. indicated the purpose of the policy was to ensure all resident/families will have means to communicate any and all concerns or complaints. When a resident or family member report a complaint or concern a resident/family concern form was started by the nurse on duty or Social Services. The resident/family concern form included, but were not limited to the following:			

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If continuation sheet

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:  155089	A. BUIL B. WINC	DING	<u>00</u>	COMPL 06/04/	ETED	
	PROVIDER OR SUPPLIER  GE HOUSE OF NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE  1023 N 20TH ST  NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	the date of the concern, name of the person filing the concern, a description of the concern, the department responsible to investigate the concern, a plan for a resolution of the concern and a follow up with the resident/family two weeks after the resolution date.  This federal tag relates to complaint IN00127901.  3.1-7(a)(2)						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE :	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	a. BUILDING 00		00	COMPL	ETED
		155089	B. WING			06/04/	2013
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.					
LIEDITAC	NE LIQUIDE DE NEV	ALCA OTLE			20TH ST		
HERITAG	BE HOUSE OF NEV	W CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
F000225	483.13(c)(1)(ii)-(ii	i), (c)(2) - (4)					
SS=D	INVESTIGATE/R						
	ALLEGATIONS/II						
		not employ individuals who					
	have been found						
		streating residents by a					
	court of law; or ha	ave had a finding entered					
	into the State nur	se aide registry concerning					
	abuse, neglect, m	nistreatment of residents or					
	• • • •	of their property; and report					
		has of actions by a court of					
	law against an en	nployee, which would					
		for service as a nurse aide					
		aff to the State nurse aide					
	registry or licensii	ng authorities.					
	The facility must of	ensure that all alleged					
	violations involvin	ng mistreatment, neglect, or					
	abuse, including i	injuries of unknown source					
	and misappropria	tion of resident property					
	are reported imm						
	administrator of the	he facility and to other					
		ance with State law					
		ed procedures (including to					
	the State survey a	and certification agency).					
	The facility must I	have evidence that all					
	alleged violations						
	•	must prevent further					
	-	hile the investigation is in					
	progress.	-					
		investigations must be					
	reported to the ac						
	-	sentative and to other					
		ance with State law					
	(including to the S						
		cy) within 5 working days of					
		if the alleged violation is					
		te corrective action must					
	be taken.	view and record	EOO	0225	Horitago House will continue to		07/04/2013
	Daseu OII III(el	view and record	LOO	0223	Heritage House will continue to	J	07/04/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED
		155089	B. WIN			06/04/2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	₹			20TH ST	
HERITAC	GE HOUSE OF NE	W CASTLE			ASTLE, IN 47362	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	review, the fac	ility failed to protect			ensure that all alleged violation	
	residents, com	plete a thorough			of verbal abuse are thoroughly	• • • • • • • • • • • • • • • • • • •
	investigation a	nd report an allegation			investigated and prevent furthe	er
	of verbal abuse	e for 1 of 1 resident			potential abuse while the investigation is in process. All	
	who met the cr	riteria for abuse			allegations will be reported to	
	(Resident #23)				officials in accordance with Sta	ate
	(* 133.23.11. // 20)	·-			law.1. The alleged incident of	
	Finding include				verbal abuse was reported to	
					surveyors on 05/28/2013. The	• • • • • • • • • • • • • • • • • • •
	Intonvious with	Resident #23 on			alleged allegation of abuse wa thoroughly investigated when	IS
					reported to the DON the day a	fter
		a.m. indicated staff			Resident #23 stated it had	itter
	,	been rude to her.			occurred. On the date Reside	ent
		ndicated CNA #1 had			#23 reported to surveyors it ha	ad
	_	eakfast tray in one			occurred and she reported it to	• • • • • • • • • • • • • • • • • • •
	morning while	she was asleep.			the DON is inaccurate. Per fac	cility
	Resident #23 i	ndicated CNA #1 yelled			investigation the later alleged	
	at her "do you	want this d tray or			statement did not occur. The CNA #1 had a witness, CNA #	2
	not." The resid	ent indicated she			that she did not say "do you w	
	started moving	her stuff off her			this dn tray or not". In	
	bedside table a	and CNA #1 said "hurry			fact witness CNA #2 informed	
	up". The reside	ent indicated she told			charge nurse that Resident #2	
		s going as fast as I			was yelling and told CNA#1 to	
		nt #23 indicated she			"kiss her a". At no time on the	
		cident to the Director			date of the alleged incident di Resident #23 ever speak to th	
		same day it happened.			DON. CNA#1 left at 2:00PM o	
		ndicated CNA #1 does			the date of the alleged inciden	
					and did not return until a thoro	
		e facility but does not			investigation had been done.	
	1	more with care.			Resident #23 left a note for the	
		ndicated she did not			DON to see her the next day.	
		of the incident but it			then made the first allegation of the incident, which was	וע
		nine months. Resident			immediately investigated.	
	#23 indicated s	she felt like CNA #1 "bit			Resident #23 also changed he	er
ı	her head off" fo	or no reason.			allegations, giving more than	
					one description of what she	
	Review of the	record of Resident #23			alleged. Resident #23 had a d	care

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVE	Y
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	A. BUILDING 00		COMPLETED	
		155089		B. WING		06/04/2013	
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	ł.		1	20TH ST		
HERITAC	GE HOUSE OF NEV	W CASTLE			ASTLE, IN 47362		
					7.6722, 117.77662		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		E	PLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG		D.	ATE
		10:50 a.m. indicated			plan than includes false		
	the resident's o	diagnoses included, but			accusations.2. Any resident making an accusation of verba		
	were not limite	d to, morbid obesity,			abuse has the potential to be	'	
	restless leg syr	ndrome, osteoarthritis,			affected. All residents making		
		sion, anxiety, back			any type of accusation of alleg	ed	
	· ·	urinary incontinence,			verbal abuse, even if care		
	insomnia, psyc	•			planned they make false		
		ertension, anemia,			accusations, will be reported to		
	urinary retention				the appropriate officials in		
	i uninary reterition	л.			accordance with State law.3. A staff will be inserviced on the	AII	
					proper reporting of alleged		
		for Resident #23, with			abuse/any & all types of abuse	on l	
		of 1-9-13, indicated the			7/1/2013. All new hires will be	. 011	
	resident made	false accusations			educated on abuse prohibition		
	about the facili	ty and staff to her			and proper reporting.4. All		
	family. The inte	erventions included, but			accusations of abuse will be		
	were not limite	d to, remind the			investigated and reported to th	е	
		gitimate complaints			apppropriate State agencies		
		will be addressed and			Attachment #6A-C. The DON		
		eeded and have 2 staff			designee will monitor reportable	е	
		oach the resident when			log weekly for 3 months then monthly for 3 months to ensure		
					complinace.These reportables		
		ner to ensure staff			be reported to the QA Commit		
	protection from	accusations.			and recommendations followed		
		te for Resident #23					
	dated 3-13-13	at 9:30 a.m. indicated					
	the resident wa	as yelling at staff and					
	Social Services	s was notified.					
	The Minimum I	Data Set (MDS)					
		r Resident #23, dated					
		ted the resident's BIMS					
	`	for Mental Status) was					
		nge of 13-15, indicating					
	the resident is	cognitively intact.					

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Event ID: VCG611

Facility ID: 000035

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	00	COMPL	
11112 12111	or conditions	155089	1	LDING		06/04/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				20TH ST		
HERITAC	GE HOUSE OF NEV	V CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
		y progress note for lated 5-2-13 indicated					
		as alert and oriented					
		he resident reported					
		nally depressed.					
	J	•					
		the DON on 5-30-13 at					
		ated the facility had not					
		able incidents to report					
	•	ent of Health related to					
	except residen	in past 6 months					
	•	hen queried about					
		eporting a CNA had					
		lled at her, the DON					
		nad a "soft file" on the					
	incident, but ha	ad not reported it to the					
	•	Health. The DON					
		t file was something					
	_	ike they did not need					
	•	Department of Health					
		keep a file on the DON indicated on					
		sident had left a note					
		alk with her. The DON					
		she went to the					
	resident's room	n to talk with her, the					
	resident report	ed that she did not					
	want CNA #1 ii						
		use she was mean.					
		ated the resident					
	•	then CNA #1 brought					
		ray in that morning, she d did not wake up right					
		#1 said to the resident					
	away and ONA	" I July to the resident					

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Event ID: VCG611

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2013 FORM APPROVED OMB NO. 0938-0391

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMP	(X5) PLETION ATE
NAME OF PROVIDER OR SUPPLIER  HERITAGE HOUSE OF NEW CASTLE  (X4) ID  PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  SUMMARY STATEMENT OF DEFICIENCES  PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE  COMP	PLETION
HERITAGE HOUSE OF NEW CASTLE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMP	PLETION
PROFILE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMP	PLETION
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMP	
	ATE
THE REGULATOR DRESC IDENTIFIES IN ORDER TOOL THE STATE OF	
"do you want this d tray?" The DON	
indicated she clarified with the	
resident that CNA #1 had cussed at	
her, and the resident indicated yes	
she had. The DON indicated Resident	
#23 indicated after CNA #1 cussed at	
her, the resident began throwing	
things and cussing at CNA #1. The	
DON indicated the resident began	
crying during their conversation and	
saying she did not understand why	
everyone hated her and that she tried to get along with everyone. The DON	
indicated when she questioned CNA	
#1 the CNA indicated she took	
Resident #23's breakfast tray in and	
the resident was asleep. CNA #1	
indicated she said the resident's	
name three times and then the	
resident said to her I don't know what	
your problem is. The CNA indicated	
the resident became upset and	
started throwing things and told her to	
kiss her a CNA #1 indicated she did	
not say anything to the resident and	
walked out of the room. The DON	
indicated CNA #2 was standing in the	
hallway during the incident and heard	
what happened, and both CNA's	
indicated that CNA #1 did not cuss at	
Resident #23. The DON indicated	
there had to be two staff in the	
resident's room at all times. The DON	
indicated the facility did not report this	
incident to the Department of Health	

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Event ID: VCG611

Facility ID: 000035

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155089	B. WIN	G		06/04/2013
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	
LIEDITA					20TH ST	
HERITAC	GE HOUSE OF NEV	W CASILE		NEW C	ASTLE, IN 47362	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENC!)	DATE
		ent #23 had it care				
	planned that sh					
		he DON indicated she				
		w any other residents				
		situation and she did				
		NA #1. The DON				
		#1 does not care for				
	Resident #23 a	inymore.				
	Intonvious with	CNA #1 on 5-30-13 at				
		ated she took Resident				
		t tray in her room on e resident was laying in				
		t her window. CNA #1				
		aid the resident's				
		ies and then the				
		up" and screamed at				
		ing. CNA #1 indicated				
		d her to get the h out				
		NA #1 indicated CNA				
		nallway and heard the				
		. CNA #1 indicated she				
		e of the nurses about				
	l .	t could not remember				
	which one.	t could not remember				
	William Onc.					
	Interview with (	CNA #2 on 5-30-13 at				
		ated she was passing				
		#1 on 3-13-13. CNA				
	1	ne was in another				
		n passing a tray when				
		ident #23 yelling so				
		e hallway and listened.				
		ted she did not hear				
		d prior to Resident #23				

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Event ID: VCG611

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155089	B. WIN			06/04/	2013
NAME OF F				STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	PROVIDER OR SUPPLIEF	C		1023 N	20TH ST		
HERITAC	GE HOUSE OF NE	W CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	•	e she was in another					
		n. CNA #2 indicated					
		ar CNA #1 cuss at the					
		#2 indicated she and					
	1	ed the incident to the					
		could not remember					
	which nurse it	was.					
	Interview with	LPN #4 on 5-31-13 at					
	9:38 a.m. indic	ated she was the nurse					
	on 3-13-13 wh	en the incident					
	happened with	Resident #23. LPN #4					
		CNA #1 and CNA #2					
		that Resident #23 was					
	· ·	indicated she talked					
		#23 on 3-13-13 and the					
		ted that CNA #1					
		LPN #4 indicated the					
		aid something about					
		her if she wanted her					
	l -	#4 indicated she told					
		care for Resident #23					
		eported the incident to					
	1 -	on as she got done					
		sident #23. When					
	· •	#1 continued to work					
		N #4 indicated yes she					
		work on 3-13-13					
		lent #23 had it care					
	pianned of mai	king false accusations.					
		Resident #23 on					
	5-30-13 at 10:0	00 a.m. indicated the					
	when CNA #1	cussed at her she was					
	shocked. Resid	dent #23 indicated she					

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Event ID: VCG611

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155089	B. WIN	G		06/04/	2013
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					20TH ST		
HERITAC	GE HOUSE OF NEV	V CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ten along with CNA #1					
		nt maybe the CNA was					
		that day. Resident #23					
		elt like CNA #1 should					
	•	trouble for cussing at					
		s satisfied that she no					
	•	r her. Resident #23					
		#4 was the one that					
		NA #1 would not be					
	caring for her a	inymore.					
	Dovious of the	Unaidanta of allogad					
		Incidents of alleged					
		provided by the Social					
		or (S.S.D.) on 5-31-13					
		dicated the residents					
	_	facility will be treated					
	with dignity and	•					
		th their individual					
		abuse is defined as					
		written, and/or					
	0	age that willfully					
	•	raging and derogatory					
		nts or their families, or					
	within hearing						
	•	allegations of abuse					
	<i>'</i>	rere not limited to, a					
	_	tigation will be initiated					
	_	ns to gather pertinent					
		d verify the occurrence,					
	•	d abusive individual is					
		t it the responsibility of					
	•	at the time of the					
	incident, if other						
		to suspend the abusive					
	employee until	the incident can be					

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155089	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	TE SURVEY PLETED 04/2013
NAME OF P	ROVIDER OR SUPPLIER	•		ADDRESS, CITY, STATE, ZIP	CODE	
	SE HOUSE OF NEV			20TH ST ASTLE, IN 47362		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	resident abuse	ed and all incidents of will be reported to the Department of Health.				

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Event ID: VCG611

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155089	B. WING		06/04/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			1 20TH ST	
HERITAC	GE HOUSE OF NEV	V CASTLE		CASTLE, IN 47362	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000226 SS=D	483.13(c) DEVELOP/IMPLM ETC POLICIES The facility must of written policies ar mistreatment, negresidents and mist property. Based on interview, the facility the policy of ab protecting resident who mallegation of veresident who mabuse (Resident Who mabuse (Resident #23 in brought her governor. The resident her "do you was could." The resident her could." Resident reported the incomplete the incomplete the incomplete her brought her brought.	develop and implement ad procedures that prohibit glect, and abuse of cappropriation of resident view and record ality failed to implement buse prevention by not dents, implementing an arrhad abuse for 1 of 1 and the criteria for an #23).		Heritage House will continue to develop and implement writter policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.1. This was repoted to the ISDH on 5/28/13. An investigation was done 3/14/2 on an allegation of alleged verabuse re: resident # 23, who had a Plan of Care stating she mandalse accusations, that was not substantiated. 2. Any resident makes an allegation of verbal abuse has the potential to be affected. All resident allegations/concerns were reviewed for the last 6 month. resident allegations of any type abuse will be reported to the appropriate State agencies with 24 hours of the incident and an investigation will be done on a allegations. 3. All resident allegations of any type of abuse will be reported to the appropriate State agencies within 24 hours the incident and an investigation will be done on all allegations. See attachments # 5 & 6. All simil be inserviced on abuse or	DATE  DATE  DATE  DATE  DO 07/04/2013  ntt,  DO 013, rbal nas kes t who has kes t who has seriate s of on on staff
	bedside table a up". The reside the CNA "I was could." Resider reported the ind Of Nursing the	and CNA #1 said "hurry ent indicated she told s going as fast as I nt #23 indicated she cident to the Director		will be reported to the appropriate agencies within 24 hour the incident and an investigation will be done on all allegations. See attachments # 5 & 6. All s	riate s of on staff

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPL	ETED
		155089	A. BUI. B. WIN			06/04/2013	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	3			20TH ST		
HERITA	GE HOUSE OF NE	W CASTLE			ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	still work at the	e facility but does not			reportables weekly for 3		
	assist her anyr	more with care.			months, monthly for 3 months,		
	Resident #23 i	ndicated she did not			then ongoing. Social Service	<b></b>	
	know the date	of the incident but it			Director or designee will monit	UI	
		nine months. Resident			complaints/concerns/grievance	es	
		she felt like CNA #1 "bit			weekly for 3 months, monthly		
	her head off" fo				3 months, then ongoing. Finding will be reported to the QA		
	Dovious of the	record of Resident #23			Committee for review and		
					recommendations. See	.:11	
		10:50 a.m. indicated			attachments # 5 & 6. All staff v	VIII	
		diagnoses included, but			7/1/2013.		
		d to, morbid obesity,			77 1720 10.		
		ndrome, osteoarthritis,					
	edema, depres	ssion, anxiety, back					
	pain, cellulitis,	urinary incontinence,					
	insomnia, psyc	chotic agitation,					
	pulmonary hyp	pertension, anemia,					
	urinary retention						
	•	for Resident #23, with					
		of 1-9-13, indicated the					
	resident made	false accusations					
	about the facili	ty and staff to her					
	family. The inte	erventions included, but					
	,	d to, remind the					
		egitimate complaints					
		will be addressed and					
		eeded and have 2 staff					
		oach the resident when					
		her to ensure staff					
	protection from	accusations.					
	The nursing no	ote for Resident #23					
	_	at 9:30 a.m. indicated					
		as yelling at staff and					
	LIC ICOIGCIIL W	ao joning at otan ana	1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155089	B. WIN	G		06/04/2013	
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					20TH ST		
HERITAC	GE HOUSE OF NEV	V CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		N
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE	
	Social Services	s was notified.					
	The National Control	2-4- 0-4 (MDO)					
		Data Set (MDS)					
		r Resident #23, dated					
		ed the resident's BIMS					
	l ,	for Mental Status) was					
		nge of 13-15, indicating					
	the resident is	cognitively intact.					
	The manual at	u nuaguaga mata fam					
		y progress note for					
		lated 5-2-13 indicated					
		as alert and oriented					
	1	he resident reported					
	feeling occasio	nally depressed.					
	Interview with t	he DON on 5-30-13 at					
		ated the facility had not					
		able incidents to report					
		ent of Health related to					
	•						
	_	in past 6 months					
	except residen						
		hen queried about					
		eporting a CNA had					
		lled at her, the DON					
		and a "soft file" on the					
		ad not reported it to the					
		Health. The DON					
		t file was something					
		ike they did not need					
	•	Department of Health					
		keep a file on the					
		OON indicated on					
		sident had left a note					
	requesting to ta	alk with her. The DON					
	indicated when	she went to the					

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII		00	COMPLETED	
		155089	B. WIN			06/04/	2013
NAME OF P	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					20TH ST		
HERITAG	GE HOUSE OF NEW	V CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG		to talk with her, the		IAG	,		DATE
		ed that she did not					
	want CNA #1 ir						
		ise she was mean.					
	_	ated the resident					
		hen CNA #1 brought					
	•	ay in that morning, she					
		d did not wake up right					
	away and CNA	#1 said to the resident					
	"do you want th	nis d tray?" The DON					
	indicated she c	larified with the					
	resident that Cf	NA #1 had cussed at					
	her, and the res	sident indicated yes					
	she had. The D	ON indicated Resident					
	#23 indicated a	fter CNA #1 cussed at					
	her, the resider	nt began throwing					
	things and cuss	sing at CNA #1. The					
	DON indicated	the resident began					
	crying during th	eir conversation and					
		not understand why					
		I her and that she tried					
		h everyone. The DON					
		she questioned CNA					
		licated she took					
		breakfast tray in and					
		s asleep. CNA #1					
		aid the resident's					
		es and then the					
		her I don't know what					
		s. The CNA indicated					
		came upset and					
		g things and told her to					
		IA #1 indicated she did					
		g to the resident and					
	walked out of th	ne room. The DON					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155089	B. WIN	G		06/04/2	013
NAME OF D	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
WANTE OF T	ROVIDER OR SOLI EIER			1023 N	20TH ST		
HERITAG	GE HOUSE OF NEV	V CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		#2 was standing in the					
	, ,	the incident and heard					
		d, and both CNA's					
		CNA #1 did not cuss at					
		The DON indicated					
		two staff in the					
		n at all times. The DON					
		acility did not report this					
		Department of Health					
		ent #23 had it care					
	planned that sh						
		he DON indicated she					
		w any other residents					
		situation and she did					
	•	NA #1. The DON					
	indicated CNA	#1 does not care for					
	Resident #23 a	anymore.					
	Interview with (	CNA #1 on 5-30-13 at					
	9:17 a.m. indic	ated she took Resident					
	#23's breakfas	t tray in her room on					
		e resident was laying in					
		t her window. CNA #1					
	indicated she s	aid the resident's					
	name three tim	es and then the					
	resident "blew	up" and screamed at					
		ing. CNA #1 indicated					
		d her to get the h out					
	of her room. Cl	NA #1 indicated CNA					
	#2 was in the h	nallway and heard the					
		. CNA #1 indicated she					
	reported to one	e of the nurses about					
	•	t could not remember					
	which one.						
	l		1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155089	A. BUI	LDING	00	COMPL 06/04/	
		100009	B. WIN			00/04/	2013
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE  20TH ST		
HERITAG	GE HOUSE OF NEV	W CASTLE			ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG		CNA #2 on 5-30-13 at		TAU			DATE
		ated she was passing					
		41 on 3-13-13. CNA					
	•	ne was in another					
		n passing a tray when					
		ident #23 yelling so					
		e hallway and listened.					
		ted she did not hear					
		d prior to Resident #23					
	, ,	e she was in another					
		n. CNA #2 indicated					
		ar CNA #1 cuss at the #2 indicated she and					
		ed the incident to the					
	•	could not remember					
	which nurse it						
	William Haras II	wao.					
	Interview with I	LPN #4 on 5-31-13 at					
	9:38 a.m. indic	ated she was the nurse					
	on 3-13-13 wh	en the incident					
	• •	Resident #23. LPN #4					
		CNA #1 and CNA #2					
	· •	that Resident #23 was					
		indicated she talked					
		#23 on 3-13-13 and the ted that CNA #1					
		LPN #4 indicated the					
		aid something about					
		her if she wanted her					
	_	#4 indicated she told					
	,	care for Resident #23					
	anymore and r	eported the incident to					
	the DON as so	on as she got done					
	_	sident #23. When					
	queried if CNA	#1 continued to work					

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Event ID: VCG611

Facility ID: 000035

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155089	B. WING	G		06/04/	2013
NAME OF P	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KO VIDEK OK SOIT EIEN				20TH ST		
HERITAG	GE HOUSE OF NEV	V CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		N #4 indicated yes she					
		work on 3-13-13					
		ent #23 had it care					
	planned of mal	king false accusations.					
	Interview with I	Resident #23 on					
		00 a.m. indicated the					
		cussed at her she was					
		dent #23 indicated she					
		tten along with CNA #1					
		nt maybe the CNA was					
		that day. Resident #23					
		elt like CNA #1 should					
		trouble for cussing at satisfied that she no					
	1	or her. Resident #23					
		#4 was the one that					
		NA #1 would not be					
	caring for her a	anymore.					
	Review of the '	'Incidents of alleged					
		provided by the Social					
		or (S.S.D.) on 5-31-13					
		dicated the residents					
		facility will be treated					
	with dignity and	_					
	, ,	th their individual					
		abuse is defined as					
		written, and/or					
	·	age that willfully					
	-	age that williany aging and derogatory					
		ents or their families, or					
	within hearing	•					
	l ·	allegations of abuse					
	inciuaea, but w	vere not limited to, a					

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155089		(X2) MULTIPLE CO A. BUILDING B. WING	X3) DATE SURVEY COMPLETED 06/04/2013		
	PROVIDER OR SUPPLIE		STREET A 1023 N	ADDRESS, CITY, STATE, ZIP CODE 20TH ST CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	of the allegation information and if the suspected and employee, the supervisor incident, if oth Administrator, employee untifully investigated resident abuse.	stigation will be initiated ons to gather pertinent of verify the occurrence, and abusive individual is it it the responsibility of at the time of the er than the to suspend the abusive of the incident can be seed and all incidents of the will be reported to the Department of Health.			

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Event ID: VCG611

Facility ID: 000035

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155089	B. WING		06/04/2013
NAME OF P	PROVIDER OR SUPPLIEI	3	STREET	ADDRESS, CITY, STATE, ZIP CODE	
TWINE OF T	NO VIDEN ON SOIT EIE			120TH ST	
HERITAC	GE HOUSE OF NE	W CASTLE	NEW (	CASTLE, IN 47362	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000241 SS=D	483.15(a) DIGNITY AND R INDIVIDUALITY The facility must in a manner and maintains or enh dignity and respe- or her individualit Based on obse- record review, provide dignity residents obse- (Resident #7)  Findings include The record of I reviewed on 5/ Resident #7's were not limite and anxiety.  Resident #7's (Minimum Data dated 4/28/13 cognition was a never/rarely m needed extens person with ea  Resident #7's, with a update of "Problem #1, r	promote care for residents in an environment that ances each resident's ect in full recognition of his ty.  ervation, interview and the facility failed to for 1 resident of 10 erved for dining.  de:  Resident #7 was /30/13 at 9:40 a.m. diagnoses, included but to to, senile dementia  Quarterly, MDS a Set), assessment, indicated Resident #7 severely impaired, ade decisions and sive assistance, one	F000241	Heritage House will continue to promote care for residents in a manner and in an environment that maintains or enhances earesident's dignity and respect full recognition of his or her individuality.1. Resident #7 had been evaluated and treated by both speech and occupational therapy. Resident #7 had a standard therapy st	o 07/04/2013  a t hich in s // rage n s. nt's re: s as was r r he t #7 t. put
	_	fingers. Goal, the intain weight through		Resident #7 has only allowed staff to assist her a very few times, this is extremely rare. T	he

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIC	00	COMPL	ETED
		155089	A. BUII B. WIN	LDING		06/04/	2013
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
LIEDITA <i>(</i>	GE HOUSE OF NEV	N CASTLE			20TH ST ASTLE, IN 47362		
ПЕКПАС	JE HOUSE OF NEV	W CASTLE		INEVV C	A31LE, IN 47302		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	next 90 days re	eview. Interventions,			DON, MDS Coordinator and o	ther	
	honor the phys	sician's ordered diet,			nurses have had no success		
	pureed, monitor weight weekly for 4				feeding the resident. This is a resident choice issue. See		
	weeks or until stable, then monthly,				attachment #7.2. Any resident		
	send dessert bowls on her tray				who refuses to be assisted wit		
		s to eat with her			meal, refuses to use eating		
	fingers.				utensils, must be on a pureed		
	Comment, 1/21/13, resident				and insists to feed self with he		
	· ·	at with fingers. She			fingers is at risk. All residents	will	
		•			be audited for their preferred	-4-	
		spoon but prefers			eating habits. Anyone who me the aforementioned criteria wil		
	fingers."				evaluated by speech therapy a		
					occupational therapy to see if	aria	
	Resident #7's	care plan, dated			their eating habits can be		
	2/20/13, "Probl	lem, resident eats			changed, if resident so desires	s.3.	
	meals with her	fingers and at times			All residents who eat pureed for	ood	
	sucks on finger	rs. Goal, resident will			with their fingers will be screer	ned	
	_	eat with her fingers, as			by speech therapy and		
		s well as episodes of			occupational therapy to see if	4la a	
		fingers. Intervention,			treatment can correct the way resident eats or if the diet can		
	_	r hands are clean and			upgraded. If treatment is	De	
					indicated it will be provided. 4.	All	
		-foods", cups, or bowls			residents will be monitored to		
	for resident to	use.			identify any resident who eats		
					pureed food with their fingers,		
		ohysician recapitulation			weekly for 3 months then mon	,	
	orders, dated 6	6/13, indicated "no			for 3 months, then as needed.	All	
	added salt/pure	eed diet."			residents identified will be referred to speech therapy and	4	
					occupational therapy for	u	
	On 5/28/13 at 3	7:34 a.m., Resident #7			evaluation &/or treatment. The	,	
		st dining room. She			Therapy Dept. Mgr. will report		
		bowls of pureed food			findings and treatments to the		
		her right finger in one			Committee quarterly for 6		
		nd the suck on her			months, then as needed.IDR:		
					There is no evidence that the	_	
	_	e approximately 1/2 of			facility did not promote care fo	r	
	1	ntinuing to put her			resident #7 in a manner &		
	I tinger in the foo	od and licking her			enviroment that maintained or		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:  155089	LDING	00	COMPLETED 06/04/2013	
	PROVIDER OR SUPPLIER  GE HOUSE OF NEV		STREET A 1023 N	ADDRESS, CITY, STATE, ZIP CODE 20TH ST ASTLE, IN 47362		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē.	(X5) COMPLETION DATE
TAG	finger  During an intermoder 7:45 a.m., CN/not to feed here at with a spoother because shountil she gets soon 5/29/13 at 1 #7 was observed putting her fing bowls with pure potatoes, pudd spoon was produse it.  During an intermoder 12:10 p.m., CN don't feed here much she will go CN 5/31/13 at 1 was observed for the state of the s	view on 5/28/13 at A #1 indicated "we try so we can get her to in instead of us feeding ne will just eat and eat ick when we feed her." I1:58 a.m., Resident ed eating lunch by er in different dessert eed food, mashed ing ground turkey. A vided but she did not  view on 5/29/13 at A #10 indicated "we because she will eat so get sick." I2:20 p.m. CNA #6 feeding Resident #7 uring the entire meal	TAG	enhanced resident's dignity & respect in full recognition of he individually. It is the residents right to eat in the manner they choose. See attached.	er e	DATE

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Facility ID: 000035

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155089		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/04/2013	
	PROVIDER OR SUPPLIE	R	1023 N	ADDRESS, CITY, STATE, ZIP CODE	00.0 %20.0
HERITAG	GE HOUSE OF NE	W CASTLE	NEW C	CASTLE, IN 47362	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F000309 SS=D	HIGHEST WELL Each resident must provide the services to attain practicable physipsychosocial we the comprehensicare.  Based on interreview, the fact necessary care provided for 3 for constipation and #18)  Findings included the service of the ser	ust receive and the facility necessary care and or maintain the highest ical, mental, and ill-being, in accordance with ve assessment and plan of eview and record cility failed to ensure e and treatment were of 6 residents reviewed in. (Resident #16, #56)  de:  d of Resident #16 was /30/13 at 8:18 a.m. is diagnoses, included mited to, chronic pain	F000309	Heritage House will continue to ensure each resident receive and the facility provides the necessary care and services attain or maintain the highest practical physical, mental and psychosocial well being in accordance with the comprehensive assessment a plan of care. 1. Residents # 10 #56, #18, have been assessed BM's monitored and laxitives given if indicated. 2. All reside with the diagnosis of constipation have the potential to be affect. These residents have been assesed and laxatives given if indicated. 3. A new procedure monitoring BM's and the administration of MOM/laxative has been implemented. See attachment #8A-C 4. The Don her designee will monitor ADL Books and BM log 5 times we times 3 months, then weekly times 3 months, then PRN. The information will be taken to the Committee for any needed accordinate in the committee for any needed accordinate.	nd 5, d, nts tion ed  f for es or ekly

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Event ID: VCG611

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155089	B. WIN	IG		06/04/	2013
NAME OF F	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
LIEDITA	SE 110110E OF NE	AV 0 A 0 T   F			20TH ST		
HERITAG	GE HOUSE OF NE	W CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		al dependence of two					
	staff						
	- always contin	ent of urine and bowel					
	Resident #16's						
	recapitulation orders, dated 6/13,						
	indicated the following:						
	<ul><li>Colace (stool softener), 100 mg</li><li>(milligrams), by mouth, daily</li><li>Lasix (diuretic), 20 mg, by mouth,</li></ul>						
	daily - Oxycontin (narcotic analgesic), 80						
	mg, by mouth,	-					
	1	ative) suppository,					
	rectally, daily,						
	- Milk of Magne	esia (laxative), by					
	mouth, daily, a	s needed					
		led "ADL (activities of					
	daily living), for	rm, dated April 2013,					
	indicated for th	e month of April, 2013,					
	Resident #16 o	did not have a bowel					
	movement on A	April, 12, 13, 14, 15, 16					
	or 17, 2013. (6	6 days without a bowel					
	movement).						
	Resident #16'	April, 2013, MAR					
	(Medication Ad	lministration Record),					
	indicated PRN	(as needed) laxatives					
	were not given	during the days of no					
	bowel moveme	ents for Resident #16.					
	A document tit	led "ADL, form, dated					
	May 2013, indi	cated for the month of					
	May, 2013, Re	sident #16 did not have					

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	VT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONST			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		155089	B. WIN			06/04/20	J13
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
LIEDITA	SE LIQUISE SE NEV	A			20TH ST		
HERITAC	GE HOUSE OF NEV	V CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	l `	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE (	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
1		nent on May, 24, 25,					
1		29, 2013. (6 days					
	without a bowe	ii movement).					
	   Desident #16'	May, 2013, MAR,					
		laxatives were not					
	· ·	e days of no bowel					
	movements for	•					
		. Coldone II To.					
	During an inter	view on 5/31/13 at					
	_	ident #16 indicated					
	·	stipated at times and it					
	•	nach hurt but they do					
		pository when I get to					
	feeling real bad	•					
		a arra it riolpo.					
	During an inter	view on 6/3/13 at 1:10					
	_	ndicated "we have a					
	l ·	xative should have					
	' '	ney did not have a					
	bowel moveme	-					
		•					
	l '	56's record was					
		31/13 at 2:18 P.M.					
		uded but were not					
		eimer's Disease,					
		agitation and anxiety,					
	and constipation	on.					
		quarterly Minimum					
		ssment, dated 5/1/13,					
		as usually understood					
		s understood others.					
		h his Brief Interview for					
	Mental Status,	indicating he was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155089		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE ( COMPL 06/04/	ETED	
	PROVIDER OR SUPPLIE			1023 N	DDDRESS, CITY, STATE, ZIP CODE 20TH ST		
HERITA	GE HOUSE OF NE	W CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		red for his cognitive ng. He was always bowel.					
	indicated the formation indicated indi	order for May, 2013, ollowing order: Milk of jular Strength 400 j)/ 5 milliliters (ml) - mouth daily as needed					
	Form for Bowe Resident #56 I movement dur frames: March 2013; April 19,	s Activity of Daily Living el Elimination indicated had not had a bowel ring the following time in 11, 12, 13, and 14, 20, 21, and 22, 2013; and 6, 2013; May 28, 29, 13.					
	Resident #56's received his M or any addition	ation was available in s record he had lilk of Magnesia PRN, nal bowel stimulant, ve noted time frames.					
	at 12:23 P.M., procedure for was to give a r the morning ar the evening (u achieved from	rith LPN #7, on 6/3/13 indicated the facility's bowel management, resident prune juice in and Milk of Magnesia in nless results were the prune juice), if a ot had a bowel					

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Event ID: VCG611

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	
		155089	B. WIN			06/04/	2013
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE HOUSE OF NE	W CASTLE			20TH ST ASTLE, IN 47362		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
		3 days. LPN #7					
		night shift nurses were review the resident's					
	1 .	y Living Form for Bowel					
		d report to the day shift					
		ed to begin the bowel					
		procedure. LPN #7					
		ident #56 received					
		ery morning with his					
	breakfast tray.	,					
	A review of Re	esident #56's meal ticket					
	indicated he re	eceived 4 ounces of					
	prune juice ev	ery morning with his					
	breakfast.	, ,					
	On 6/4/13 at 8	3:49 A.M., LPN #7					
	indicated she	was unable to locate					
	any document	ation Resident #56 had					
	received his M	lilk of Magnesia PRN,					
	,	nal bowel stimulant,					
		ne juice, during the					
		frames: March 11, 12,					
	l ' '	013; April 19, 20, 21,					
		May 3, 4, 5, and 6,					
	2013; May 28,	, 29, 30, and 31, 2013.					
		//40L					
	· '	#18's record was					
		/4/13 at 9:33 A.M.					
	•	cluded but were not					
		us post motor vehicle					
		severe brain injury, and					
	constipation.						
	Resident #18's	s quarterly Minimum					

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Event ID: VCG611

Facility ID: 000035

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	T OF DEFICIENCIES				NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155089	B. WIN	IG		06/04/2	2013
NAME OF P	ROVIDER OR SUPPLIER	3		STREET A	DDRESS, CITY, STATE, ZIP CODE		
WANTE OF T	ROVIDER OR SOLVEIE				20TH ST		
HERITAG	GE HOUSE OF NE	N CASTLE		NEW CA	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ssment, dated 5/1/13,					
		as usually understood					
	and understood others. He scored 9						
	on his Brief Into	erview for Mental					
	Status, indicati	ng he was moderately					
	impaired for his	s cognitive decision					
	making. He wa	as always incontinent					
	of bowel.						
	Resident #18's	s physician					
	recapitulation order for June, 2013,						
	indicated the fo	ollowing orders: Milk of					
	Magnesia Reg	ular Strength 400 mg/5					
	ml - Give 30 m	I by mouth every other					
	•	onstipation. Bisacodyl					
	suppository 10	mg - Insert 1					
	suppository red	ctally daily PRN for					
	constipation if	no bowel movement for					
	3 days.						
	Resident #18's	Activity of Daily Living					
	Form for Bowe	l Elimination indicated					
	Resident #18 h	nad not had a bowel					
	movement duri	ing the following time					
	frames: March	n 3, 4, 5, 6, and 7,					
		28, 29, and 30, 2013;					
	•	and 10, 2013; May 18,					
	19, 20, and 21	-					
	No documenta	tion was available in					
		record, he had					
		rune juice, his Milk of					
	, ,	I, his Bisacodyl					
	_	RN, or any additional					
		it, during the above					
		it, daining the above					

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	OF CORRECTION	IDENTIFICATION NUMBER:			00	(X3) DATE COMPL	
		155089	A. BUII B. WIN	LDING		06/04/	
			b. Will		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	2			20TH ST		
HERITAC	GE HOUSE OF NEV	W CASTLE		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	noted time fran			TAG	BLI (CLE.C.)		DATE
	noted time han	1163.					
	On 6/4/13 at 1:	51 P.M., LPN #7					
		vas unable to locate					
	any documenta	ation Resident #18 had					
	received prune	juice, his Milk of					
	Magnesia PRN	l, his Bisacodyl					
		RN, or any additional					
		t during the following					
		March 3, 4, 5, 6, and 7,					
		28, 29, and 30, 2013;					
	•	and 10, 2013; May 18,					
	19, 20, and 21	, 2013.					
	The most curre	ent Bowel Elimination					
		by the Administrator					
		20 A.M., indicated the					
		icy: It is the policy of					
	_	residents who have					
	not had a bowe	el movement within					
	three (3) days,	shall be evaluated and					
	appropriate act	tion taken. Purpose:					
		ination occurs to avoid					
	•	nd discomfort for the					
		edure: 1.) CNA's shall					
	· •	BM Record to document					
	` '	vel movements. 2.)					
	_	s's shall review the BM					
		are bowel movements					
		at least every three (3)					
	_	sence of extenuating istances that would					
		dent from eliminating					
	l '	ast every three (3)					
		on, should a resident					
	Ladyo. III additi						

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Event ID: VCG611

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If continuation sheet

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	00	(X3) DATE SURVEY  COMPLETED
	155089	A. BUILDING		06/04/2013
		B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		20TH ST	
HERITAC	GE HOUSE OF NEW CASTLE		ASTLE, IN 47362	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
TAG	inform the staff that their normal	TAG		DATE
	pattern bowel movements occur more			
	that every three (3) days, this will be			
	discussed with the physician and			
	documented in the medical chart. 3.)			
	If the resident has not had a bowel			
	movement within three (3) days (and			
	in the absence of the above			
	extenuating circumstances) the			
	licenses nurse shall proceed as			
	follows: >Obtain an order and			
	administer a stool softener. >Provide			
	prune juice at least daily."			
	3.1-37(a)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: VCG611

Facility ID: 000035

If continuation sheet

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155089	A. BUII	LDING	ONSTRUCTION 00	(X3) DATE : COMPL 06/04/	ETED
		133009	B. WIN	_		00/04/	2013
	ROVIDER OR SUPPLIER SE HOUSE OF NEV			1023 N	ADDRESS, CITY, STATE, ZIP CODE  20TH ST  ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
F000312 SS=D	483.25(a)(3) ADL CARE PROVERESIDENTS A resident who is activities of daily increased on observed review, provide assistation using eating utility of the record review, provide assistation using eating utility of the record of Frederick (Resident #7)  Findings include The record of Frederick on 5/3 Resident #7's of were not limited and anxiety.  Resident #7's of (Minimum Data dated 4/28/13 incognition was an ever/rarely maneded extension person with eating the record of the record of Frederick (Minimum Data dated 4/28/13 incognition was an ever/rarely maneded extension with eating the record of Frederick (Minimum Data dated 4/28/13 incognition was an ever/rarely maneded extension with eating the record of Frederick (Minimum Data dated 4/28/13 incognition was an ever/rarely maneded extension with eating the record of Frederick (Minimum Data dated 4/28/13 incognition was an ever/rarely maneded extension with eating the record of Frederick (Minimum Data dated 4/28/13 incognition was an ever/rarely maneded extension with eating the record of Frederick (Minimum Data dated 4/28/13 incognition was an ever/rarely maneded extension with eating the record of Frederick (Minimum Data dated 4/28/13 incognition was an ever/rarely maneded extension with eating the record of Frederick (Minimum Data dated 4/28/13 incognition was an ever/rarely maneded extension with eating the record of Frederick (Minimum Data dated 4/28/13 incognition was an ever/rarely maneded extension with eating the record of Frederick (Minimum Data dated 4/28/13 incognition was an ever/rarely maneded extension with eating the record of Frederick (Minimum Data dated 4/28/13 incognition was an ever/rarely maneded extension with eating the record of Frederick (Minimum Data dated 4/28/13 incognition was an ever/rarely maneded extension with eating the record of Frederick (Minimum Data dated 4/28/13 incognition was an ever/rarely maneded extension with eating the record of Frederick (Minimum Data dated 4/28/13 incognition was an ever/rarely maneded extension wi	unable to carry out iving receives the es to maintain good g, and personal and oral rvation, interview and the facility failed to nce with dining and ensils for 1 resident of eserved for dining.  e:  Resident #7 was 30/13 at 9:40 a.m. diagnoses, included but d to, senile dementia  Quarterly, MDS a Set), assessment, indicated Resident #7 severely impaired, ade decisions and ive assistance, one	F00	0312	Heritage House will continue to ensure that a resident who unable to carryout the activitie daily living receives the neces services to maintain good nutrition, grooming, and perso and oral hygiene.1. Resident has been evaluated and treate by both speech and occupatio therapy. We have contacted tresident's family re; her eating habits. Family stated resident eaten with her fingers for a lor time. They also tried to correct this but failed. They have no concerns re: resident eating wher fingers at its her choice. The Ombudsman, was also contacted re: Resident #7 eati with her fingers. It is her opinion that the resident has the right eat with her fingers. A spoon provided on Resident #7 food tray, she chooses not to use it She will at times allow staff to the edge of the spoon in her mouth but will not eat. Staff do attempt to feed resident #7. Resident #7 has only allowed staff to assist her a very few times. The DON, MDS Coordinator and other nurses have had no success feeding resident. This is a resident	s of sary  nal #7 ed nal he has ng t t tith mg on to is put	07/04/2013

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Event ID: VCG611

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. building 00 completed			ETED	
		155089				06/04/2	2013
			B. WINC		ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
LIEDITAC		M CASTI F			20TH ST ASTLE, IN 47362		
ПЕКПАС	GE HOUSE OF NE	W CASTLE		INEVV C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	resident to ma	intain weight through			choice issue.2. Any resident w		
	next 90 days r	eview. Interventions,			refuses to be assisted with me	eal,	
	honor the phys	sician's ordered diet,			refuses to use eating utensils, must be on a pureed diet and		
	pureed, monito	or weight weekly for 4			insists to feed self with her fing	ners	
	weeks or until	stable, then monthly,			is at risk. All residents will be		
		powls on her tray			audited for their preferred eati	ng	
		s to eat with her			habits. Anyone who meets the		
	fingers.	o to out man nor			aforementioned criteria will be		
	Comment, 1/2	1/13 resident			evaluated by speech therapy a	and	
	· ·				occupational therapy to see if		
	continues to eat with fingers. She starts out with spoon but prefers				their eating habits can be changed, if resident so desires		
					All residents who require pure		
	fingers."				food and eat wth their fingers		
					be screened by speech therap		
	Resident #7's	care plan, dated			and occupational therapy to se	ee if	
	2/20/13, "Prob	lem, resident eats			treatment can correct the way	the	
	meals with her	fingers and at times			resident eats. If treatment is		
	sucks on finge	rs. Goal, resident will			indicated it will be provided. 4.		
	be allowed to	eat with her fingers, as			The DON or their designee wi monitor residents to identify a		
		s well as episodes of			resident who needs assistance	-	
		fingers. Intervention,			with eating, 5 times a week for	-	
	1	r hands are clean and			months then weekly for 3 mon		
		r-foods", cups, or bowls			then as needed. All residents		
	for resident to	•			identified will be referred to		
	l loi lesidelli to	use.			speech therapy and occupation	nal	
	D : - : - : - : 4 # <b>7</b> ! -				therapy for evaluation &/or treatment. The report findings		
		physician recapitulation			and treatments will be submitt	ed	
		6/13, indicated "no			to the QA Committee quarterly		
	added salt/pur	eed diet."			6 months, then as needed. Se		
					attachment #9 A-BIDR: There		
	On 5/28/13 at	7:34 a.m., Resident #7			no evidence that the facility di		
	was in the ass	ist dining room. She			not provide ADL care to reside		
	had 3 dessert	bowls of pureed food			#7. Resident #7 has the right to		
		her right finger in one			choose to eat in any manner s wishes. See attached.	orie	
	<u> </u>	nd the suck on her			wishes. See allacheu.		
		e approximately 1/2 of					
	•	ntinuing to put her					
		minumy to put Hel					

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	OF CORRECTION  OF CORRECTION  155089	(X2) MULTIPLE CO  A. BUILDING  B. WING	ONSTRUCTION  00	COM	TE SURVEY  MPLETED  04/2013
	PROVIDER OR SUPPLIER  GE HOUSE OF NEW CASTLE	1023 N	ADDRESS, CITY, STATE, ZIP CO 20TH ST ASTLE, IN 47362	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	OULD BE	COMPLETION
	without difficulty.  3.1-38(a)(2)(D)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155089	B. WING		06/04/2013		
				ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIE	R					
LIEDITA		MA CACTLE	1023 N 20TH ST NEW CASTLE, IN 47362				
HERITAG	GE HOUSE OF NE	W CASTLE	NEW C	ASTLE, IN 47302			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F000323	483.25(h)						
SS=D	FREE OF ACCID	DENT					
	HAZARDS/SUP	ERVISION/DEVICES					
	The facility must	ensure that the resident					
	environment rem	nains as free of accident					
	hazards as is po	ssible; and each resident					
	receives adequa	te supervision and					
	assistance devic	es to prevent accidents.					
	Based on obse	ervation, interview and	F000323	Heritage House will continue to	o 07/04/2013		
	record review,	the facility failed to		ensure that the resident			
	follow fall inter	•		environment remains as free of			
		ective fall interventions		accident hazards as is possibl	e;		
	•	ents reviewed for falls		and each resident receives			
				adequate supervision and			
	of 4 who met of			assistance devices to prevent			
	(Resident # 3)			accidents.1. Resident #3			
				continues to be encouraged to			
	Findings include	de:		eat snacks out of room, which she continues to refuse to do.			
	J			Continues to eat snacks in her			
	On 5/20/13 at	1:35 p.m. Resident # 3		room. Food and fluids are pla			
		-		on bedside table to avoid spilli			
		sitting in her wheelchair		Staff continues to attemp to ke	~		
	_	with blue/green/yellow		room free of debris. Observati			
	bruising noted	all over her facial area.		of Resident # 3 on 6/4/2013 I			
				Administrator indicated minute	-		
	Record review	on 6/4/13 at 9:30 a.m.		pieces of debris on floor. The			
	indicated Resi	dent # 3's Minimum		largest piece of brown debris (	(1		
		essment dated 4/15/13		piece)was no large than a			
				little fingernail. Very hard to se	ee		
		ef Interview for Mental		on a brown floor behind the			
		score of 05 which		residents wheelchair. Residen			
	indicated cogn	iition was severely		would not have been able to s			
	impaired.			debris. Surveyor had to brush	the		
	•			minute pieces into her hand,			
	Review of nurs	sing notes dated		unable to pick up with fingers.			
		•		Any resident who attempts to	-		
		ted "Resident yelling		up something on the floor from wheelchair is at risk. All reside			
	•	n. 'help me, I've fallen		in wheelchair is at risk. All reside			
	out of my whe	elchair.' Resident found		will be evaluated by Occupation			
	lying in hallwa	y in front of room. Large		Therapy and their	, i.e.		
			I	1			

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Event ID: VCG611

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		155089	B. WIN		<del></del>	06/04/2013	
			Б. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER		1023 N 20TH ST				
HERITA <i>C</i>	GE HOUSE OF NEV	V CASTLE	NEW CASTLE, IN 47362				
					7.6722, 117.77662		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG		5.112	
		eft side of forehead			recommendations followed3. residents in wheelchairs will ha		
	and left eye (	Order received to send			a new fall risk assessment	ave	
	to ER (emerge	ncy room) for			completed & referred to therap	ov if	
	evaluation and	treatment."			indicated.4. Fall notification log		
					located with the 24 hr. report a		
	Review of Care	Plan for falls dated			each nurses station is to be fill		
	12/12/12, indic				out with each fall. DON or her		
	· ·	nultiple risk factors for			designee will monitor 5 times		
		•			weekly times 3months and		
	falls such as:dementia, use of psychotropic medication, history of falls, decreased mobility. Goal:				weekly times 3 months., then a		
					needed. The report will be give to the QA Committee for reviev	l l	
					and recommendations.	, v	
		ustain no injuries due			Attachment # 1AIDR: There is	no	
	to fall thru next	review. Approach:			evidence that facility did not		
	Reacher provid	led-instructed on use			ensure resident enviroment		
	9/26/12. Discor	ntinue does not use it.			remained as free of accident		
	(no date)				hazards as possible. See		
	, ,	encouraged to have			attached.		
		er room in view of staff					
	5/10/13.	ier reem in view or stan					
		and and fluids on					
	-	ood and fluids on					
	bedside table t						
	· ·	led- encourage her to					
		pps something on the					
	floor 5/29/13.						
	Post Fall Asses	ssment and Follow-up					
		e DON on 6/4/13 at					
		cated Resident # 3 on					
		fall with injury. Type of					
		na left forehead/eye,					
	left knee abras	•					
		What interventions					
		ited? Try to keep room					
	- hallway free f	rom debris so Resident					
	won't try to clea	an					

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Event ID: VCG611

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155089	B. WING		06/04/2013		
NAME OF F	PROVIDER OR SUPPLIE	₹		ADDRESS, CITY, STATE, ZIP CODE			
LIEDITA		ALCA CTL F	1023 N 20TH ST NEW CASTLE, IN 47362				
HERITAC	GE HOUSE OF NE	W CASTLE	NEW C	ASTLE, IN 47362			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEI ICIENCI )	DATE		
		ou trying to do - per					
	resident statement. Pick up popcorn						
	dropped on the	e noor.					
	Observation of	Decident # 2 on 6/4/12					
		Resident # 3 on 6/4/13					
	-	ndicated she was in her her wheelchair with a					
	_	vithin reach on her bed,					
	the handle of the reacher was turn away from the Resident. Resident # 3						
	indicated "I don't know what that (pointing at reacher) is."						
	l	particles on floor in					
		sident. Resident # 3					
		er wheelchair in her					
	_	ating cheese and					
	crackers.	and cheese and					
	ordonoro.						
	Observation of	Resident # 3's room					
	on 6/4/13 at 1:						
		ndicated food particles					
		to be corn chips on the					
		here the Resident was					
	sitting in her w						
	Review of the	Fall Management					
		d by the Administrator					
	, ,	20 a.m. indicated					
		determine those					
		are at risk for falling. 2.					
		plan of care with the					
	1	erventions to decrease					
	a residents risl						
		Document specific					
		ls and approaches on					
	' , 5	11					

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Event ID: VCG611

Facility ID: 000035

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:  155089	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COMP	ESURVEY LETED 1/2013	
	PROVIDER OR SUPPLIER  SE HOUSE OF NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE  1023 N 20TH ST  NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH- CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	the residents care plan. 4. Review and up date the care plan with scheduled reviews or as resident's condition changes					
	3.1-45(a)(2)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155089	B. WING		06/04/2013	
NAME OF F	PROVIDER OR SUPPLIE	3	STREET	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	NO VIDER OR SOLVEIL			20TH ST		
HERITAC	GE HOUSE OF NE	W CASTLE	NEW CASTLE, IN 47362			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
TAG F000371	REGULATORY OF 483.35(i)	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
SS=F	The facility must (1) Procure food considered satisf local authorities; (2) Store, prepar under sanitary considered on obsethe facility failed prepared in a considered satisfactory.	RE/SERVE - SANITARY - from sources approved or factory by Federal, State or and e, distribute and serve food onditions ervation and interview, ed to ensure food was clean and sanitary	F000371	Heritage House will continue maintain an effective pest con program, so that the facility wi remain free of pests and roder	trol II	
	to affect 48 of	This had the potential 52 residents who s from 1 of 1 dietary		1.The pest control company treated the kitchen 5/22/13, fo fruit flies, not gnats, we did no have gnats. These terms have both been used but the pest	r t	
	Findings includ	de:		control company said it was fri flies. It was suggested by then that the floor under the		
	department on accompanied I the following war - On the count prepared for the	er were drinks were ne residents, a drink		dishwasher be replaced. Maintenance replaced floor or 5/22/13. Pest control returned 6/3/13, surveyor was made aw of this. They stated problem w getting better. They installed fi fly traps, silent trap insect light and treated all drains. He suggested we replace screen	on vare as cuit	
	with a straw in	ne of the employees, it, 1/2 full and from a urant, was observed idents' drinks.		exit door to kitchen. We repla entire kitchen door on 6/11/13 We also had grease trap jetted Attachment #12-D. Dietary developed a new procedure to clean nozzles of the juice	d.	
	-	er to clean the dietary I not have any chlorine		machine. Attachment # 13.A and no time after surveyor's initial of dietary, did she return to chon fruit flies, even after Adm.	tour eck	
	- Several gnate	s were observed		informed her the fruit flies were much better and even after sh		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVE	Υ
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLETED	
		155089	A. BUII B. WIN			06/04/2013	
			D. WIIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	8					
LIEDITAC		ALCASTI E	1023 N 20TH ST NEW CASTLE, IN 47362				
ПЕКПАС	BE HOUSE OF NEV	W CASTLE		INEVV C	ASTLE, IN 47362		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COM	PLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		ATE
	around the disl	nwasher and the juice			was informed of 6/3/13		
	area.	•			treatment. Surveyor's intervie	w	
					of resident #26 is questioned.		
	An interview w	ith the Dietary Manager			Surveyor states, resident # 26		
		· ·			stated" in the dinning room the	re	
		7:50 a.m., indicated an			are gnats all over the wall."		
		left the drink on the			Resident #26 has advanced macular degeneration and has		
		unter, the pail of water			said he cannot see. This is		
	to clean the pre	eparation counter did			documented on his medical		
	not have chlori	ne in it and they had			record. His cognition is also		
	been having gr	nats. She also			moderately impaired. See		
		vould look at when pest			attachment # 14 A-D. Pest cor	itrol	
	control had be	<del>-</del>			company returned 6/20/13 and	ı	
	Control Had bed	en there last.			installed commercial fly light a	nd	
	0.4.04(1)(0)				replaced fruit fly traps.		
	3.1-21(i)(3)				Attachment 15.A-B. On 6/26/1		
					American Pest Control will do		
					entire pest control bomb of the		
					dietary dept. to ensure all fruit		
					flies are gone 2. All residents		
					the facility who receive food from the kitchen have the potential		
					be affected. The pest control	.0	
					company treated the kitchen		
					5/22/13 & 6/3/2013 for fruit flie	s	
					They installed fruit fly traps, sil		
					trap insect light, and treated al		
					drains. 3.We will continue ou		
					monthly pest control visits.		
					Maintenance or their designee		
					monitor for fruit flies (gnats) in	the	
					kitchen, dinning room and		
					kitchenette . 4. Maintenance o		
					their designee will monitor for the flies (gnats) in the kitchen,	ruit	
					dinning room and kitchenette f	ive	
					times a week for 3 months, on		
					time a week for 3 months and		
					needed. See attachment #16.		
					They will report their findings to	, l	
					the QA Committee for review		

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155089	B. WING	-	06/04/2013		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
			1023 N 20TH ST				
HERITAG	GE HOUSE OF NEV	W CASTLE	NEW C	CASTLE, IN 47362			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG				
				IDR: There is no evidence th			
				the facility did not store, prep distribute and serve food und			
				sanitary conditions. See attach			
				Tamany Conditions. Coo dita			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155089	B. WIN			06/04/	2013
NAME OF B	DOLUDED OD GLIDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1023 N	20TH ST		
HERITAG	SE HOUSE OF NEV	V CASTLE		NEW CASTLE, IN 47362			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
F000469 SS=C	PROGRAM	ECTIVE PEST CONTROL					
	The facility must maintain an effective pest control program so that the facility is free of pests and rodents.						
	•	rvation and interview,	F00	0469	Heritage House will continue to	o İ	07/04/2013
		d to maintain an			maintain an effective pest conf	trol	
	_	control program. There			program, so that the facility wil		
	-	served in the dietary			remain free of pests and roder	nts.	
	_	room and kitchenette			1.The pest control company treated the kitchen 5/22/13, for	r	
	for the resident				fruit flies,. It was suggested by		
	potential to affect 52 of 52 residents				them that the floor under the		
	residing in the				dishwasher be replaced.		
	roolaing in the	idolity.			Maintanance replaced floor on		
	Findings includ	۵:			5/22/13. Pest control returned		
	i ilialings iliciaa	C.			6/3/13. They stated problem v getting better. They installed fr		
	During the initia	al tour of the dietary			fly traps, silent trap insect light		
	_	5/28/13 at 7:34 a.m.,			and treated all drains. He	<i>'</i>	
	•	· ·			suggested we replace screen		
	•	by the Dietary Manager,			exit door to kitchen. We replace		
	_	served around the			entire kitchen door on 6/11/13. We also had grease trap jetted		
	dishwasher and	d the juice area.			Attachment #12-D. Dietary	۷.	
	O= 5/00/40 =1/	2.40			developed a new procedure to	,	
		3:19 a.m., gnats were			clean nozzels of the juice		
	, ,	around one resident's			machine. Attachment # 13.A.		
	plate during bre	eaktast.			Surveyors interview of residen	t	
					#26 is questioned. Surveyor states, resident # 26 stated" in	the	
		11:00 a.m., gnats were			dinning room there are gnats a		
	observed near				over the wall." Resident #26 ha		
	resident's kitch	enette.			advanced macular degeneration	on	
					and has said he cannot see. T	his	
	Review of a se	rvice slip/invoice, from			is documented on his medical		
	a local pest cor	ntrol, dated 5/16/13,			record. His cognition is also moderately impaired. See		
	indicated durin	g a visit to the facility			attachment # 14 A-D. Pest cor	ntrol	
	the target was	ants. They also			company returned 6/20/13 and		
	checked the fly	lights, baited for ants			installed commercial fly light a		

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STATEMEN	NT OF DEFICIENCIES	NCIES X1) PROVIDER/SUPPLIER/CLIA X2		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED		
		155089	A. BUII B. WIN			06/04/2	2013	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	₹			20TH ST			
LIEDITA <i>(</i>	GE HOUSE OF NE\	N CASTLE			ASTLE, IN 47362			
ПЕКПАС	JE HOUSE OF NEV	W CASTLE		INEVV C	ASTLE, IN 47302			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	NCED TO THE APPROPRIATE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE	
	in the laundry i	oom and checked all			replaced fruit fly traps.Attachm	ent		
	monitors.				15.A-B. On 6/26/13 American			
	Review of a service slip/invoice, from				Pest Control will do an entire properties control bomb of the dietary de			
					to ensure all fruit flies are gone			
		ntrol, dated 5/20/13,			All residents in the facility who			
	-	t was spiders and ants,			recieve food from the			
	_	or was sprayed.			kitchen have the potential to b	e		
	and the extend	was sprayed.			affected. The pest control			
	During on inter	wiow on E/29/12 of			company treated the kitchen			
	During an interview on 5/28/13 at 7:45 a.m., the Dietary Manager indicated they had been having some gnats in the kitchen.				5/22/13, for fruit flies, not gnate	S,		
					we did not have gnats It was	0.5		
					suggested by them that the flo under the dishwasher be	OI		
					replaced. Maintenance replace	ed le		
					floor on 5/22/13. Pest control			
	During an inter	view on 5/28/13 at			returned on 6/3/13. He			
	11:00 a.m., Re	sident #26, indicated			suggested we replace screen	in		
	"in the dining re	oom there are gnats all			exit door to kitchen. We replace			
	over the wall."	Ü			entire kitchen door on 6/11/13	I		
		record was reviewed			We also had grease trap jetted	j.		
	on 5/29/13 at 1				Attachment #12D. Dietary develpoed a new procedure to			
		MDS (Minimum Data			clean nozzels of the juice	'		
		-			machine. Attachment # 13 F	Pest		
	, ·	ent, dated 3/7/13,			control company returned 6/20			
		dent #26's BIMS (Brief			and installed commercial fly lig			
		ental Status), scored			and replaced fruit fly			
	·	e of 8-12 indicating			traps.Attachment #15.A-B 3.W	/e		
	Resident #26's	cognition was			will continue our monthly pest			
	moderately imp	paired.			control visits. Maintenance or their designee will monitor for	fruit		
					flies (gnats) in the kitchen,	ii uit		
	During an inter	view on 6/3/13 at			dinning room and kitchenette.	4.		
	_	Administrator indicated			Maintenance or their designee			
		aware of gnats being a			monitor for fruit flies (gnats) in			
	problem and pest control had been to				kitchen, dinning room and			
		5/16/13 and 5/20/13.			kitchenette five times a week f			
		ated the facility was			3 months, one time a week for	3		
		•			months and as needed. See	\		
		est control to come out			attachment #16. They will repo	) ונ		
	i again, and the	y had moved the			their findings to the QA			

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	T OF DEFICIENCIES  OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155089	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM	TE SURVEY PLETED 04/2013		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP	CODE			
HERITAG	GE HOUSE OF NEV	V CASTLE	1023 N 20TH ST NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	bananas and s	ome of the other fruit.		Committee for review recommendations.	and			
	3.1-19(f)(4)			recommendations.				

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